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ATTENTION ALL PATIENTS

Every day new insurance companies are forming and existing insurance companies are changing. Consequently, it is impossible for us to know exactly what your insurance company will cover.

Please check with your insurance carrier so you will be aware of your coverage regarding office visits, x-rays, blood tests, emergency visits, surgeries, etc. It is to your benefit to be well informed to prevent having to pay for a service that may have been covered if you had a referral, prior authorization, second opinion, etc.

- If you do not inform us of any insurance changes, you will be responsible for the services rendered.
- If your insurance plan does not cover services that are rendered, you will be responsible for those services.
- You are responsible for paying for all copays due and previous balances owed at the time of your appointment or your appointment will be rescheduled.
- If you have no insurance, you are responsible for all services rendered. Talk to us about payment plan arrangements.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process my insurance claims.

I hereby authorize GI Medicine Associates, PC to apply for benefits on my behalf for covered services rendered by them or by their order. I request the payment from my insurance company to be made directly to GI Medicine Associates, PC (or to the party who accepts assignment).

I permit a copy of this authorization to be used in place of the original.

I certify that the information that I have reported with regard to my insurance coverage is correct.

_____ _____
Patient Signature (Parent/Guardian) Date

_____ _____
Please Print Name Date of Birth

_____ _____
Address, City, State, Zip Last 4 digits of SSN